

8664

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Fred.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
11 TOWN Frederick		3 yrs.		TOWN Rural Hope Hill		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS II8 East Street				STREET ADDRESS (If rural give location) Rural Hope Hill			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Cora Dillon Allen				Sept. 20 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		Colored		Widowed		Sept 1, 1876	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: (If UNDER 1 YEAR) (If UNDER 24 HRS.)		79 yrs.	
Housewife		*****		Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Cookstown, New Jersey				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel Stout				Josephine Wilkenson			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		219-07-9510 A		Grant Allen-- II8 East Street			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.1 Immediate cause (a) CORONARY ARTERY sclerosis with DUE TO ACUTE MYOCARDIAL infarction						1 day	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) GENERALIZED ARTERIOsclerosis DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
		m.					
22. I hereby certify that I attended the deceased from 10-16, 1953, to 9-20, 1955, that I last saw the deceased alive on 9-19, 1955, and that death occurred at 4 A.M., from the causes and on the date stated above.							
SIGNATURE (Degree or title)				DATE SIGNED			
Bur R. Martin, M.D.				35E Church Frederick, Md.			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept 24, 1955		Fairview		Frederick, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 22, 1955		Frank R. Smith, Jr.		Charles E. Hicks III		Fred. Md.	
DEPUTY LOCAL REGISTRAR							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

SEP 26 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. *1*

871

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <i>Rural - Mt. Airy</i>		<i>6 months</i>		TOWN <i>Rural - Mt. Airy</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Route 1 - Sidney Road</i>				STREET ADDRESS (If rural give location) <i>Route 1 Sidney Road</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last) <i>Henry Charles Bennett</i>				OF DEATH: <i>Sept. 8 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>Colored</i>	<i>MARRIED</i>	<i>March 20, 1890</i>	<i>65</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Abraham Bennett</i>				14. MOTHER'S MAIDEN NAME: <i>Grace Young</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>1226 W. Saratoga Baltimore, Md.</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Luetic Aortitis</i>				<i>Unknown</i>			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Syphilis</i>				<i>Unknown</i>			
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 30, 1955</i> , to <i>Sept. 8, 1955</i> , that I last saw the deceased alive on <i>Aug. 24, 1955</i> , and that death occurred at <i>5:15 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>W.B. Caldwell</i>				ADDRESS <i>Mt. Airy, Md.</i>		DATE SIGNED <i>Sept 8, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9-11-1955</i>		<i>Bushey Park</i>		<i>Howard Co. Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Sept. 9, 1955</i>		<i>Blair A. Runkles</i>		<i>C.M. Waltz</i>		<i>Winfield, Md.</i>	

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 13 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8665		Item 21a, 21b, 21c, 21d, 21e, 21f, 21g, 21h, 21i, 21j, 21k, 21l, 21m, 21n, 21o, 21p, 21q, 21r, 21s, 21t, 21u, 21v, 21w, 21x, 21y, 21z, 21aa, 21ab, 21ac, 21ad, 21ae, 21af, 21ag, 21ah, 21ai, 21aj, 21ak, 21al, 21am, 21an, 21ao, 21ap, 21aq, 21ar, 21as, 21at, 21au, 21av, 21aw, 21ax, 21ay, 21az, 21ba, 21bb, 21bc, 21bd, 21be, 21bf, 21bg, 21bh, 21bi, 21bj, 21bk, 21bl, 21bm, 21bn, 21bo, 21bp, 21bq, 21br, 21bs, 21bt, 21bu, 21bv, 21bw, 21bx, 21by, 21bz, 21ca, 21cb, 21cc, 21cd, 21ce, 21cf, 21cg, 21ch, 21ci, 21cj, 21ck, 21cl, 21cm, 21cn, 21co, 21cp, 21cq, 21cr, 21cs, 21ct, 21cu, 21cv, 21cw, 21cx, 21cy, 21cz, 21da, 21db, 21dc, 21dd, 21de, 21df, 21dg, 21dh, 21di, 21dj, 21dk, 21dl, 21dm, 21dn, 21do, 21dp, 21dq, 21dr, 21ds, 21dt, 21du, 21dv, 21dw, 21dx, 21dy, 21dz, 21ea, 21eb, 21ec, 21ed, 21ee, 21ef, 21eg, 21eh, 21ei, 21ej, 21ek, 21el, 21em, 21en, 21eo, 21ep, 21eq, 21er, 21es, 21et, 21eu, 21ev, 21ew, 21ex, 21ey, 21ez, 21fa, 21fb, 21fc, 21fd, 21fe, 21ff, 21fg, 21fh, 21fi, 21fj, 21fk, 21fl, 21fm, 21fn, 21fo, 21fp, 21fq, 21fr, 21fs, 21ft, 21fu, 21fv, 21fw, 21fx, 21fy, 21fz, 21ga, 21gb, 21gc, 21gd, 21ge, 21gf, 21gg, 21gh, 21gi, 21gj, 21gk, 21gl, 21gm, 21gn, 21go, 21gp, 21gq, 21gr, 21gs, 21gt, 21gu, 21gv, 21gw, 21gx, 21gy, 21gz, 21ha, 21hb, 21hc, 21hd, 21he, 21hf, 21hg, 21hh, 21hi, 21hj, 21hk, 21hl, 21hm, 21hn, 21ho, 21hp, 21hq, 21hr, 21hs, 21ht, 21hu, 21hv, 21hw, 21hx, 21hy, 21hz, 21ia, 21ib, 21ic, 21id, 21ie, 21if, 21ig, 21ih, 21ii, 21ij, 21ik, 21il, 21im, 21in, 21io, 21ip, 21iq, 21ir, 21is, 21it, 21iu, 21iv, 21iw, 21ix, 21iy, 21iz, 21ja, 21jb, 21jc, 21jd, 21je, 21jf, 21jg, 21jh, 21ji, 21jj, 21jk, 21jl, 21jm, 21jn, 21jo, 21jp, 21jq, 21jr, 21js, 21jt, 21ju, 21jv, 21jw, 21jx, 21jy, 21jz, 21ka, 21kb, 21kc, 21kd, 21ke, 21kf, 21kg, 21kh, 21ki, 21kj, 21kl, 21km, 21kn, 21ko, 21kp, 21kq, 21kr, 21ks, 21kt, 21ku, 21kv, 21kw, 21kx, 21ky, 21kz, 21la, 21lb, 21lc, 21ld, 21le, 21lf, 21lg, 21lh, 21li, 21lj, 21lk, 21ll, 21lm, 21ln, 21lo, 21lp, 21lq, 21lr, 21ls, 21lt, 21lu, 21lv, 21lw, 21lx, 21ly, 21lz, 21ma, 21mb, 21mc, 21md, 21me, 21mf, 21mg, 21mh, 21mi, 21mj, 21mk, 21ml, 21mm, 21mn, 21mo, 21mp, 21mq, 21mr, 21ms, 21mt, 21mu, 21mv, 21mw, 21mx, 21my, 21mz, 21na, 21nb, 21nc, 21nd, 21ne, 21nf, 21ng, 21nh, 21ni, 21nj, 21nk, 21nl, 21nm, 21nn, 21no, 21np, 21nq, 21nr, 21ns, 21nt, 21nu, 21nv, 21nw, 21nx, 21ny, 21nz, 21oa, 21ob, 21oc, 21od, 21oe, 21of, 21og, 21oh, 21oi, 21oj, 21ok, 21ol, 21om, 21on, 21oo, 21op, 21oq, 21or, 21os, 21ot, 21ou, 21ov, 21ow, 21ox, 21oy, 21oz, 21pa, 21pb, 21pc, 21pd, 21pe, 21pf, 21pg, 21ph, 21pi, 21pj, 21pk, 21pl, 21pm, 21pn, 21po, 21pp, 21pq, 21pr, 21ps, 21pt, 21pu, 21pv, 21pw, 21px, 21py, 21pz, 21qa, 21qb, 21qc, 21qd, 21qe, 21qf, 21qg, 21qh, 21qi, 21qj, 21qk, 21ql, 21qm, 21qn, 21qo, 21qp, 21qq, 21qr, 21qs, 21qt, 21qu, 21qv, 21qw, 21qx, 21qy, 21qz, 21ra, 21rb, 21rc, 21rd, 21re, 21rf, 21rg, 21rh, 21ri, 21rj, 21rk, 21rl, 21rm, 21rn, 21ro, 21rp, 21rq, 21rr, 21rs, 21rt, 21ru, 21rv, 21rw, 21rx, 21ry, 21rz, 21sa, 21sb, 21sc, 21sd, 21se, 21sf, 21sg, 21sh, 21si, 21sj, 21sk, 21sl, 21sm, 21sn, 21so, 21sp, 21sq, 21sr, 21ss, 21st, 21su, 21sv, 21sw, 21sx, 21sy, 21sz, 21ta, 21tb, 21tc, 21td, 21te, 21tf, 21tg, 21th, 21ti, 21tj, 21tk, 21tl, 21tm, 21tn, 21to, 21tp, 21tq, 21tr, 21ts, 21tt, 21tu, 21tv, 21tw, 21tx, 21ty, 21tz, 21ua, 21ub, 21uc, 21ud, 21ue, 21uf, 21ug, 21uh, 21ui, 21uj, 21uk, 21ul, 21um, 21un, 21uo, 21up, 21uq, 21ur, 21us, 21ut, 21uu, 21uv, 21uw, 21ux, 21uy, 21uz, 21va, 21vb, 21vc, 21vd, 21ve, 21vf, 21vg, 21vh, 21vi, 21vj, 21vk, 21vl, 21vm, 21vn, 21vo, 21vp, 21vq, 21vr, 21vs, 21vt, 21vu, 21vv, 21vw, 21vx, 21vy, 21vz, 21wa, 21wb, 21wc, 21wd, 21we, 21wf, 21wg, 21wh, 21wi, 21wj, 21wk, 21wl, 21wm, 21wn, 21wo, 21wp, 21wq, 21wr, 21ws, 21wt, 21wu, 21wv, 21ww, 21wx, 21wy, 21wz, 21xa, 21xb, 21xc, 21xd, 21xe, 21xf, 21xg, 21xh, 21xi, 21xj, 21xk, 21xl, 21xm, 21xn, 21xo, 21xp, 21xq, 21xr, 21xs, 21xt, 21xu, 21xv, 21xw, 21xx, 21xy, 21xz, 21ya, 21yb, 21yc, 21yd, 21ye, 21yf, 21yg, 21yh, 21yi, 21yj, 21yk, 21yl, 21ym, 21yn, 21yo, 21yp, 21yq, 21yr, 21ys, 21yt, 21yu, 21yv, 21yw, 21yx, 21yy, 21yz, 21za, 21zb, 21zc, 21zd, 21ze, 21zf, 21zg, 21zh, 21zi, 21zj, 21zk, 21zl, 21zm, 21zn, 21zo, 21zp, 21zq, 21zr, 21zs, 21zt, 21zu, 21zv, 21zw, 21zx, 21zy, 21zz		08672	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		No. 131			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND	STATE <u>Va.</u> COUNTY <u>Fairfax</u>				
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>83x-3</u>				
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp. Dead on arrival</u>	STREET ADDRESS (If rural, give location) <u>Emerson Street</u>				
3. NAME OF DECEASED: (Type or Print) <u>Willard</u> (First) <u>Justin</u> (Middle) <u>Breckenridge</u> (Last)	4. DATE OF DEATH <u>Sept. 11</u> 19 <u>55</u>				
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>1/8/1921</u>		
9. AGE last birthday: <u>34</u> yrs.	10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u>	11. IF UNDER 24 HRS. Hours <u>11</u> Mins. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Officer</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>US Park Police</u>	11. BIRTHPLACE (State or foreign country): <u>Loudoun County, Va.</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: <u>Charles C. Breckenridge</u>	14. MOTHER'S MAIDEN NAME: <u>Hazel Herrell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.: <u>no</u>	17. INFORMANT & ADDRESS: <u>Charles V. Breckenridge</u> <u>Laughlin Avenue, McLean, Virginia</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		<u>823x</u>			
Immediate cause (a) <u>Broken neck</u>	DUE TO	<u>10 minutes</u>			
Antecedent cause(s) (b) <u>Automobile accident</u>	DUE TO				
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH					
19a. DATE OF OPERATION: <u>9-14-55</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>	21c. (City or town) <u>near Shomont</u> (County) <u>Frederick</u> (State) <u>MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9</u> <u>11</u> <u>1955</u> <u>9:35</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto ran off road & struck a tree</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>B. B. Thomas</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>9/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>9-14-55</u>	NAME OF CEMETERY OR CREMATORY <u>Nat. Mem. Park Cem.</u>	LOCATION (City, town, or county) (State) <u>Falls Church - Va.</u>		
DATE REC'D BY LOCAL REG. <u>13 Sept. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	24. FUNERAL DIRECTOR <u>A. H. Jones Co.</u>	ADDRESS <u>2901 14th NW. Wash. D.C.</u>		

BUREAU V. S.

SEP 14 1955

RECEIVED

CERTIFICATE OF DEATH

87-2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Burkittsville</i>		<i>life</i>		TOWN <i>Burkittsville</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <i>Robert</i>		(Middle) <i>Lee</i>		(Last) <i>Brown</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>5-17-1955</i>	9. AGE last birthday yrs. <i>3</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>3</i>	Hours <i>1955</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Herbert Grim</i>				14. MOTHER'S MAIDEN NAME: <i>Betty L. Brown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS: <i>Betty Brown</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
421.4 IMMEDIATE CAUSE (A) <i>Endocardial Sclerosis</i>						<i>Autopsy</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION: <i>—</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July</i> , 1955, to <i>Sept 3</i> , 1955, that I last saw the deceased alive on <i>Aug 16</i> , 1955, and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J E Harp</i>		M. D. <i>Middleton</i>		DATE SIGNED <i>9-3-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-4-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Laurel Valley Ch. & Cr. Cem.</i>		LOCATION (City, town, or county) (State) <i>Frederick Co., Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9-3-1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth V. Hersh</i>		24. FUNERAL DIRECTOR <i>Leadhill Co., Middletown, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

RECEIVED

SEP 7 1955

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

08674

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

8703

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R. D. #5	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Edgemont		STREET ADDRESS (If rural, give location) Edgemont	
3. NAME OF DECEASED (Type or Print) LUCY (First) KATE (Middle) BRUST (Last)		4. DATE OF DEATH September 16, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 28, 1876
9. AGE last birthday 78 yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin H. Davis		14. MOTHER'S MAIDEN NAME Rebecca Coblentz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Mr. B. A. H. Brust, Frederick R.D.#5, Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 974X Immediate cause (a) Strangulation by hanging Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH seconds
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home		(CITY OR TOWN) Frederick R.D. 5 (COUNTY) Frederick (STATE) Md	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE B. A. H. Brust (Degree or title) Dep. Med. Exam.,		DATE SIGNED 9/17/1955	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
DATE REC'D BY LOCAL REG. 17 Sept 1955		LOCATION (City, town, or county) (State) Frederick, Maryland	
REGISTRAR'S SIGNATURE Elizabeth G. Heck		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 20 1955

RECEIVED

8666

08675

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 131

1. PLACE OF DEATH: <i>Frederick Memorial Hospital</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>11 TOWN</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <i>OR TOWN Mt. Airy-Rural-R. D. 568-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Memorial Hosp. Frederick Md</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <i>John</i> (Middle) (Last) <i>Burns</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>September 12, 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widower</i>	8. DATE OF BIRTH: <i>1874 ?</i>
9. AGE last birthday: <i>80?</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>?</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Charles Burns</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Hopkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY No.: <i>219-03-2682</i>	
17. INFORMANT & ADDRESS: <i>Carl Anderson, Mt. Airy, R.D., Maryland</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>Fracture base of Skull</i>			<i>7 hrs</i>
DUE TO			
Antecedent cause(s) (b) <i>Struck by automobile</i>			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Struck by automobile on Route 40</i>			
19a. DATE OF OPERATION: <i>8</i>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Highway</i>	
21c. (City or town) (County) (State) <i>Route 40 Howard Md</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>9 11 1955 7:30 M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Struck by automobile</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>B. Thomas</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Sept 12-55</i>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>Sept. 14, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Friendship Cemetery</i>		LOCATION (City, town, or county) (State) <i>Carroll County, Maryland</i>	
DATE REC'D BY LOCAL REG. <i>Sept. 12, 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth G. Herb</i>	
24. FUNERAL DIRECTOR <i>C. M. Walsh Funeral Home, Winfield, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08676

Reg. Dist. No. 131

8667

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Fred.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> LENGTH OF STAY (in this place) <u>1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> 35	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hospital West 4th Street</u>		STREET ADDRESS (If rural, give location) <u>West 13</u> 1	
3. NAME OF DECEASED (Type or Print) <u>William R. Bussard</u>		4. DATE OF DEATH (Month) <u>9</u> (Day) <u>25</u> (Year) <u>1953</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-11-1909</u> 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Robert L. Bussard</u>		14. MOTHER'S MAIDEN NAME <u>Grace Bean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT <u>R. L. Bussard Brunswick Md</u>

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			34 yr
148X Immediate cause (a) <u>Carcinoma - throat</u>			
Antecedent cause(s) (b) <u>None</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1952, to Sept 24, 1953, that I last saw the deceased alive on Sept 24, 1953, and that death occurred at 4 P m. from the causes and on the date stated above.

SIGNATURE H. K. Keene M.D. ADDRESS Frederick Md DATE SIGNED Sept 26 53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>9-28-55</u>	<u>Park Heights</u>	<u>Brunswick</u>	<u>Md</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>26 Sept. 1955</u>	<u>Elizabeth B. Heck</u>	<u>C. A. Zeit + Co</u>	<u>Brunswick Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08677

8668

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FREDERICK</u>		<u>5 Weeks</u>		TOWN <u>Frederick Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>THREE Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u>505 Magnolia Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Priscilla</u> (First) <u>Comp</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>11 OCT 1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis, Left middle cerebral artery</u>				INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>				<u>1 year</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>23 Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>23 Sept</u> , 19 <u>55</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas E Stone</u> M.D.				ADDRESS (Street, city, town, state) <u>4 W 3rd St</u>		DATE SIGNED <u>9-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Phelos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westport Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Frank R. Smith Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u>		ADDRESS <u>Westport Md</u>	
DATE <u>9/23/55</u>		<u>Dep. Registrar</u>		<u>By P.D.</u>			

CERTIFICATE OF DEATH

Form No. 101

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. PLACE OF INTERMENT

13. NAME OF MINISTER

14. NAME OF FUNERAL HOME

15. NAME OF CEMETERY

16. NAME OF BURIAL

17. NAME OF CREMATION

18. NAME OF INCINERATION

19. NAME OF DISPOSITION

20. NAME OF OTHER

21. NAME OF OTHER

22. NAME OF OTHER

23. NAME OF OTHER

24. NAME OF OTHER

25. NAME OF OTHER

26. NAME OF OTHER

27. NAME OF OTHER

28. NAME OF OTHER

29. NAME OF OTHER

30. NAME OF OTHER

31. NAME OF OTHER

32. NAME OF OTHER

33. NAME OF OTHER

34. NAME OF OTHER

35. NAME OF OTHER

36. NAME OF OTHER

37. NAME OF OTHER

38. NAME OF OTHER

39. NAME OF OTHER

40. NAME OF OTHER

41. NAME OF OTHER

42. NAME OF OTHER

43. NAME OF OTHER

44. NAME OF OTHER

45. NAME OF OTHER

46. NAME OF OTHER

47. NAME OF OTHER

48. NAME OF OTHER

BUREAU V. B.

SEP 28 1955

RECEIVED

ENCLOSURE

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>X Rural-Middletown</i>				<i>Rural-Middletown X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) ^a <i>Alice</i> (Middle) <i>F</i> (Last) <i>DAVIDSON</i>				4. DATE OF DEATH: (Month) <i>9</i> (Day) <i>16</i> (Year) <i>1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>2-15-1861</i>	
9. AGE last birthday: <i>94</i> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>nurse</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John W. Davidson</i>		14. MOTHER'S MAIDEN NAME: <i>Martha Snook</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Clarence Bussard</i>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
<i>420.1</i>				<i>10 min</i>			
Immediate cause							
(a) <i>Acute Coronary Thrombosis</i>							
Antecedent causes (s)							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
(b) <i>Arteriosclerosis, generalized</i>				<i>unknown</i>			
(c)							
19. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 16, 1955</i> to <i>Sept 16, 1955</i> , that I last saw the deceased alive on <i>Sept 15, 1955</i> , and that death occurred at <i>4:45 P</i> from the causes and on the date stated above.							
SIGNATURE <i>Janet C. Benson</i>		(Degree or title) <i>M.D.</i>		ADDRESS <i>Middletown Md</i>		DATE SIGNED <i>Sept 16, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>19 Sept 1955</i>		<i>Mount Olivet Cemetery</i>		<i>Frederick, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>19 Sept 1955</i>		<i>Frank R. Smith, Jr.</i>		<i>C. E. Cline & Son</i>		<i>Frederick Md</i>	
		DEPUTY LOCAL REGISTRAR					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08679

8705

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Fredrick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Fredrick</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Rural-- Thurmont</u>		<u>Lifetime</u>		TOWN <u>Rural-- Thurmont</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>HOWARD</u>		(Middle) <u>CALVIN</u>		(Last) <u>DAVIS</u>		(Month) (Day) (Year)	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 25 1900</u>	
9. AGE last birthday: <u>55</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Maintenance</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>McClellan Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Yingling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-10-5883</u>		17. INFORMANT'S ADDRESS: <u>Mr. Ralph Scruton, Thurmont (rural)</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>434.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Heart disease, Congestive heart failure</u>						6 mos.	
DUE TO							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 10 1955</u> to <u>Sept 9 1955</u> that I last saw the deceased alive on <u>Sept 3 1955</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James T. Gray</u>				DATE SIGNED <u>9-10-55</u>			
M. D. <u>Thurmont Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 12</u>		<u>Blue Ridge Cemetery</u>		<u>Thurmont, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 12, 1955</u>		<u>Blanche S. Eyles</u>		<u>M. L. Creager & Son</u>		<u>Thurmont, Md.</u>	

NOTIFICATION OF DEATH

20 15

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

REPORT MADE BY

DATE OF REPORT

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

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EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

BUREAU V. S.

SEP 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8776 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				08680 Reg. Dist.	
Item 22 Film 187-10-145 See: 21C					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 131					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Fredrick</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>Fredrick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Dickerson, Md.</u>	
TOWN <u>Near Dickerson</u>				STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Dickerson</u>					
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>William Robert Diggs</u>			<u>Sept. 17 1953</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-6-1902</u>	9. AGE last birthday: <u>53</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B & O. R.R.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Robert Diggs</u>			14. MOTHER'S MAIDEN NAME: <u>Laura Davis</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Gun shot wound below left</u>					
Antecedent cause(s) (b) <u>Asilla penetrating left lung +</u>					<u>15 minutes</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Heart</u>					<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>)		21c. (City or town) (County) (State) <u>Near Dickerson Fredrick Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9 17 1953</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>B. J. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/17/53</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9/21/53</u>		NAME OF CEMETERY OR CREMATORY <u>Portersville</u>	
LOCATION (City, town, or county) (State) <u>Portersville, Md.</u>		DATE REC'D BY LOCAL REG. <u>9/21/53</u>		REGISTERAR'S SIGNATURE <u>Glynneth S. Zech</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>			

BUREAU V. S.

SEP 28 1953

RECEIVED

8659

CERTIFICATE OF DEATH

Reg. Dist. No.

08681

131

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
11 <u>TOWN</u> <u>Frederick</u>				OR <u>W. Main</u> <u>06-27-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Frederick Memorial Hospital</u>				<u>W. Main</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Missouri</u> (First) <u>Everhart</u> (Middle) <u></u> (Last)				<u>Sept. 13</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>Dec. 13, 1871</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Frederick</u>				<u></u>		<u>Md.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Bankert</u>				<u>not known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>Beatrice Hahn</u> <u>W. Main</u> <u>Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
904.0 IMMEDIATE CAUSE							
(A) <u>Shock</u>							
DUE TO							
ANTECEDENT CAUSE (S):							
(B) <u>Fracture Hip</u>							
DUE TO							
(C) <u>Accidental Fall</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>None</u>				<u></u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?	
<u>Sept 13 5:55 PM</u>						<u>Fall at home</u>	
22. I hereby certify that I attended the deceased from <u>Sept 13</u> , 19 <u>55</u> , to <u>Sept 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>55</u> , and that death occurred at <u>1230 P</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>E. P. Thomas</u> M. D.				<u>Sept 18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 15, 1955</u>		<u>W. Main</u>		<u>W. Main</u> <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 13, 1955</u>		<u>Elizabeth B. Heck</u>		<u>Bankert</u>		<u>W. Main</u> <u>Md.</u>	

BUREAU V. S.

RECEIVED
SEP 16 1955

8670

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>FREDERICK</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN FREDERICK</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Woodsboro</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 FREDERICK MEMORIAL</u>		HOSPITAL		STREET ADDRESS (If rural give location) <u>RTE #1</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>EVELYN MARIE FOGLE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>SEPT 25 1955</u>			
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Infant.</u>	8. DATE OF BIRTH: <u>SEPT 22, 1955</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HRS. Days <u>3</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Infant.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Infant.</u>		11. BIRTHPLACE (State or foreign country): <u>Fred. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME: <u>MAX RAY FOGLE</u>				14. MOTHER'S MAIDEN NAME: <u>MARY JANE WOLFE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mother-Mrs. MAX FOGLE-Woodsboro</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Anecephalus</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/22, 1955</u> to <u>9/25, 1955</u> that I last saw the deceased alive on <u>9/24, 1955</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harvey Grace</u> M.D.				ADDRESS <u>35 E Church</u>		DATE SIGNED <u>9-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/26-1955</u>		<u>Mt Hope Cem</u>		<u>Woodsboro Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>26 Sept. 1955</u>		<u>Elizabeth B. Heck</u>		<u>M. E. Creagden</u>		<u>Thurmont Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GOVERNMENT BOND

EX-100



BUREAU V. 1

SEP 28 1955

RECEIVED

General office - not the same
for the purpose of the

8671

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 Frederick		LENGTH OF STAY (in this place) 1 week		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Thurmont X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Three Pines Nursing Home				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last) George Baker Fout				4. DATE (Month) (Day) (Year) OF DEATH: Sept. 26 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED: Single	8. DATE OF BIRTH: April 3. 1868	9. AGE last birthday: 87 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work			10B. KIND OF BUSINESS OR INDUSTRY: Hotels		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Fout				14. MOTHER'S MAIDEN NAME: Lucretia Shook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. No 214-16-1080		17. INFORMANT & ADDRESS: Mrs Amy Munshour Thurmont MD			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332 X IMMEDIATE CAUSE (A) Cerebral Thrombosis						2 weeks	
ANTECEDENT CAUSE (B) Cerebral Arteriosclerosis						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) None							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION: None					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 18, 1955, to Sept. 26, 1955, that I last saw the deceased alive on Sept. 18, 1955, and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 28, 1955		NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.		LOCATION (City, town, or county) Frederick, Md	
DATE REC'D BY LOCAL REGISTRAR 27 Sept. 1955		REGISTRAR'S SIGNATURE Elizabeth S. Heik.		24. FUNERAL DIRECTOR M.L. Creager & Son.		ADDRESS Thurmont Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5831

DEPARTMENT OF HEALTH

UNITED STATES OF AMERICA

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D.C.

Division of Field Operations

Office of the Chief of Bureau

Office of the Assistant Chief of Bureau

Office of the Assistant Chief of Bureau

Office of the Assistant Chief of Bureau

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BUREAU V. 1

SEP 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08684

8797

CERTIFICATE OF DEATH

Reg. Dist. No. 1134

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Emmitsburg		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) Emmitsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (First) (Middle) (Last) Harry Robert Gelwicks				4. DATE (Month) (Day) (Year) OF DEATH: Sept 29th. 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: June 17. 1877	9. AGE last birthday: 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Emmitsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: George Gelwicks				14. MOTHER'S MAIDEN NAME: Barbara Gelwicks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-7845		17. INFORMANT & ADDRESS: Marie F. Gelwicks Emmitsburg Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of Prostate with metastases to pelvis						7 years	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/31 , 19 55 , to 9/29 , 19 55 , that I last saw the deceased alive on 9/29 , 19 55 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.							
SIGNATURE Charles R. Williams		M. D. Emmitsburg Md		DATE SIGNED Sept 30 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 3. 1955		NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		LOCATION (City, town, or county) (State) Emmitsburg Fredk. Co. MD	
DATE REC'D BY LOCAL REGISTRAR Oct 2-1955		REGISTRAR'S SIGNATURE M. F. Shuff		24. FUNERAL DIRECTOR M. L. Creager & Son		ADDRESS Thurmont. MD	

RECEIVED

RECEIVED

8708

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Middletown</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Sydnor Claude Gordon</i>		OF DEATH: <i>9 10 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>male</i>	<i>white</i>	<i>married</i>	<i>5-18-1894</i>
9. AGE last birthday		IF UNDER 1 YEAR	
<i>61 yrs.</i>		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>farm tenant</i>		<i>farm</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Virginia</i>		<i>U.S.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Benjamin Gordon</i>		<i>Barbara MacDonald</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>9</i>		<i>219-20-0284</i>	
17. INFORMANT & ADDRESS:			
<i>Mrs. Avery Gordon, Middletown, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>		<i>15 min</i>	
ANTECEDENT CAUSE (S) (B) <i>Arterio-Sclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-10</i> , 1955, to <i>9-10</i> , 1955, that I last saw the deceased alive on <i>9-10</i> , 1955, and that death occurred at <i>8:20 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>J. E. Harp</i>		DATE SIGNED <i>9-10-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Burial</i>		<i>9-13-1955</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Edge Hill Cemetery</i>		<i>Charlestown, D.C.</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>Eligible B. Heck</i>		<i>Gladhill Co., Middletown, Md.</i>	

RECEIVED

SEP 14 1955

BUREAU V. S.

8672

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8686
 No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick	LENGTH OF STAY (in this place) 20 years	CITY (If outside corporate limits write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural, give location) 431-A West South Street	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) WILLIAM	(Middle) JOSEPH	(Last) GOUKER	(Month) September 26 (Day) 19 (Year) 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: March 7, 1921
9. AGE last birthday: 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Machinist	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William I. Gouker		14. MOTHER'S MAIDEN NAME: Clara R. Zimmerman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY No.: 214-10-3822	
17. INFORMANT & ADDRESS: Mrs. William J. Gouker - Frederick, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		3 1/2 days
Immediate cause (a) Ruptured liver with hemorrhage Antecedent cause(s) (b) Infarct pancreas Diseases or conditions, if any, giving rise to the above cause (c) Suppression of kidneys stating underlying cause last (c) Fracture ribs & side hemorrhage in lungs		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 12/25/55	19b. MAJOR FINDING OF OPERATION: Ruptured liver infarct of pancreas	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg, etc., OF INJURY: 1630 West 40	21c. (City or town) (County) (State) 10 Frederick, Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: 9/23/55 8:20 M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Automobile under truck tractor
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE: B. D. Thomas		DATE SIGNED: 10/1/55
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: Sept. 28, 1955	NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
DATE REC'D BY LOCAL REG. 28 Sept. 1955	REGISTRAR'S SIGNATURE: Elizabeth G. Hebe	LOCATION (City, town, or county) (State): Frederick, Maryland
24. FUNERAL DIRECTOR: C. E. Cline & Son - Frederick, Maryland		ADDRESS:

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 4

SEP 30 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08687

8673

CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town.) <i>Frederick</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Myersville</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred. Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Dolly R. Green</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>9 8 1955</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>	8. DATE OF BIRTH: <i>1-8-1894</i>	9. AGE last birthday: <i>61</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>		11. BIRTHPLACE (State or foreign country): <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>
13. FATHER'S NAME: <i>John Hurd</i>				14. MOTHER'S MAIDEN NAME: <i>Isabella</i>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Chester Green, Myersville, Md.</i>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Acute Coronary Occlusion</i>						<i>10 min</i>	
ANTECEDENT CAUSE (B) <i>Coronary artery disease</i>						<i>2-3 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>arteriosclerosis generalised</i>						<i>?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/21</i> , 19 <i>55</i> , to <i>9/7</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9/7</i> , 19 <i>55</i> , and that death occurred at <i>5:50A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Kenneth A. Skenson</i>		ADDRESS <i>Middletown, Md.</i>		DATE SIGNED <i>9/8/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-10-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Pleasant Walk U.B.Cem.</i>		LOCATION (City, town, or county) (State) <i>Frederick Co., Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9-9-1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth B. Hack</i>		24. FUNERAL DIRECTOR <i>Gladhill Co.</i>		ADDRESS <i>Middletown, Md.</i>	

RECEIVED
SEP 13 1935
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8674

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08688

131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		LENGTH OF STAY (in this place) 14 Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 47 East Third Street				STREET ADDRESS (If rural give location) 47 East Third Street			
3. NAME OF DECEASED: (First) (Middle) (Last) GORDON LOY GREENAWALT				4. DATE (Month) (Day) (Year) OF DEATH: September 18, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: June 8, 1902	
9. AGE last birthday: 53 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10b. KIND OF BUSINESS OR INDUSTRY: Army Camp		9. AGE last birthday: 53 yrs.	
11. BIRTHPLACE (State or foreign country): West Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: George W. Greenawalt				14. MOTHER'S MAIDEN NAME: Josephine Lough			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-18-7715		17. INFORMANT & ADDRESS: 47 East Third Street, Mrs. Helen K. Greenawalt, Frederick, Maryland	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Thrombosis with						6 wks.	
ANTECEDENT CAUSE (S) DUE TO hemiplegia, right side							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Cardiovascular disease						2 yrs.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 3 , 19 55 , to Sept 18 , 19 55 , that I last saw the deceased alive on Sept 16 , 19 55 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
SIGNATURE Henry V. Chase		M. D. Frederick, Maryland		DATE SIGNED 9/19/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 21, 1955		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Kline, Pendleton Co., W. Virginia	
DATE REC'D BY LOCAL REGISTRAR 20 Sept 1955		REGISTRAR'S SIGNATURE Frank R. Smith, Jr.		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

DEPUTY LOCAL REGISTRAR

RECEIVED

SEP 21 1955

BUREAU V. S.

8675

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	CITY <i>Frederick</i>	CITY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	LENGTH OF STAY (on this place) <i>Years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>60 136 W. Patrick St.</i>		STREET ADDRESS (If rural give location) <i>136 W. Patrick St.</i>	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH:	(Month) (Day) (Year)
<i>ANNA BELL HOFF</i>		<i>Sept. 2</i>	<i>1955</i>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<i>Female</i>	<i>white</i>	<i>widow</i>	<i>5/29/1867</i>
9a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<i>housewife</i>	<i>at home</i>	<i>Maryland</i>	<i>U.S.</i>
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
<i>Amos Mentzer</i>	<i>Henrietta Martin</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
<i>no</i>	<i>none</i>	<i>Gessie J. Mull, Frederick, Md.</i>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>arterio sclerotic heart disease</i>		<i>over 2 years</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?
22. I hereby certify that I attended the deceased from <i>April</i> , 1953, to <i>Sept. 2</i> , 1955, that I last saw the deceased alive on <i>Sept. 2</i> , 1955, and that death occurred at <i>7:00 P.M.</i> , from the causes and on the date stated above.		
SIGNATURE	(Degree or title)	ADDRESS DATE SIGNED
<i>Robt Martin M.D.</i>		<i>35 E Church Frederick, Md. 9-3-55</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>9/5/55</i>	<i>Beaver Dam Cem. Union Bridge Rural</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>Sept 13/55</i>	<i>Elizabeth H. Heck</i>	<i>Powell & Hartzler</i>
		<i>Woodstock, Md</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08690

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Knoxville</i>		LENGTH OF STAY (in this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Knoxville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>—</i>				STREET ADDRESS (If rural, give location) <i>—</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <i>Mildred Louise Huffer</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>9 21 19 55</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>6-3-1902</i>	9. AGE last birthday: <i>53</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Joseph A. Swope</i>				14. MOTHER'S MAIDEN NAME: <i>Reliah Virts</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>Paul R. Huffer, Knoxville, Maryland</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
580X Immediate cause (a) DUE TO <i>Death yellow atrophy of brain</i>				14 hrs.			
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>8</i>				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6</i>, 19 <i>55</i> ., to <i>9-21</i> ., 19 <i>55</i> ., that I last saw the deceased alive on <i>9-21</i> ., 19 <i>55</i> ., and that death occurred at <i>8:00</i> p.m., from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				DATE SIGNED <i>9-23-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>9-24-55</i>		NAME OF CEMETERY OR CREMATORY: <i>Reformed</i>		LOCATION (City, town, or county) (State): <i>Knoxville Maryland</i>	
DATE REC'D BY LOCAL REG: <i>Sept 23-55</i>		REGISTRAR'S SIGNATURE: <i>Kathryn H. Brown</i>		24. FUNERAL DIRECTOR: <i>C. H. Zelt & Co Brunswick Md.</i>			

RECEIVED

SEP 27 1955

BUREAU V. S.

8576

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Frederick</i>		LENGTH OF STAY (in this place) <i>13 hrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Frederick, Maryland 11</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>244 West 5th Street</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>JANIS Louise James</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>9 17 19 55</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>1 6 84 55</i>	9. AGE last birthday: <i>71</i> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Frederick, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Robert James, Jr.</i>				14. MOTHER'S MAIDEN NAME: <i>SARA Louise Simpson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>9-</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS: <i>Hospital Records</i>			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Adrenal Cortical Hemorrhage</i>						<i>10 hours</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>16 84</i> , 19 <i>55</i> , to <i>17 84</i> 19 <i>55</i> that I last saw the deceased alive on <i>17 84</i> , 19 <i>55</i> , and that death occurred at <i>11 54</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>A. J. Power</i>		M. D. <i>220 N. ...</i>		DATE SIGNED <i>17 Sept 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-19-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>		LOCATION (City, town, or county) (State) <i>Frederick, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>19 Sept 1955</i>		REGISTRAR'S SIGNATURE <i>Frank R. Smith, Jr.</i>		24. FUNERAL DIRECTOR <i>C.E. Cline & Son - Frederick, Maryland</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 21 1953

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08692

CERTIFICATE OF DEATH

Reg. Dist. No. 131

Item 8, Film G186 9-16-55 et

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>101 E. 2nd ST</u>		STREET ADDRESS (If rural, give location) <u>101 East 2nd ST</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>Louise</u> (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) <u>9</u> (Day) <u>2</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1914/11/21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>40</u> yrs.
13. FATHER'S NAME <u>H. Johnson</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Family Records</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Brashear</u>		17. INFORMANT <u>Family Records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 6</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>422.2 Immediate cause (a) <u>Myocarditis</u></p> <p>Antecedent cause(s) (b) <u>Cerebral Hemorrhage</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
OF INJURY		m.			

22. I hereby certify that I attended the deceased from Sept 5-3, 1955, to Sept 2/55, 1955, that I last saw the deceased alive on Sept 2/55, 1955, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE E.P. Thomas (Degree or title) ADDRESS Frederick Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>9/4/55</u>	<u>Frederick</u>	<u>Frederick</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>3 Sept. 1955</u>		<u>Elizabeth B. Heck</u>		<u>H. E. Carlisle, Frederick Md</u>	

BUREAU V. S.

SEP 7 1955

RECEIVED

8678

CERTIFICATE OF DEATH

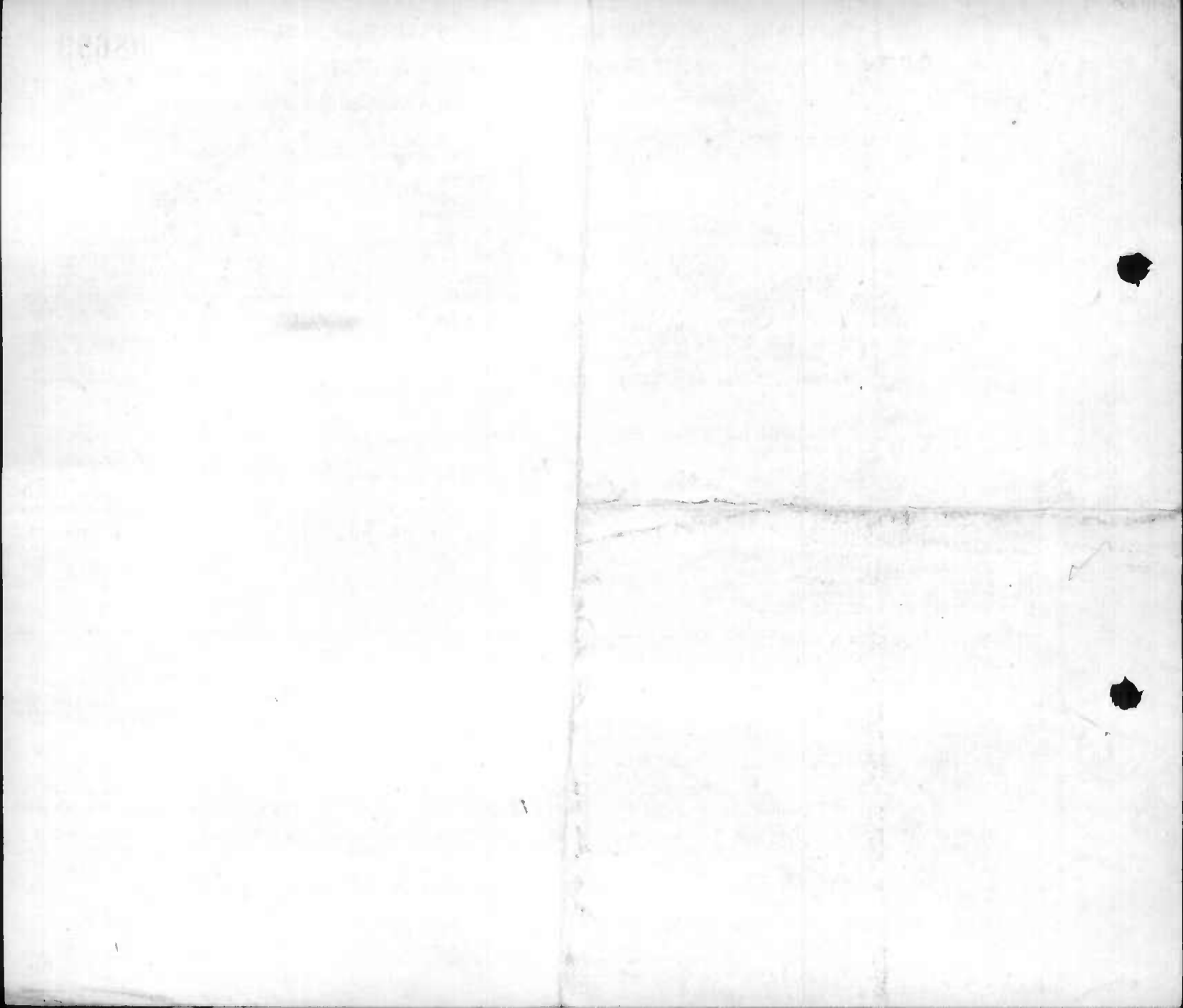
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MARYLAND <i>FREDERICK</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>FREDERICK</i> OR TOWN <i>35 YEARS</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>506 W. 2ND STREET</i>				STATE <i>MARYLAND</i> COUNTY <i>Frederick</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>FREDERICK</i> OR TOWN <i>11</i> STREET ADDRESS (If rural give location) <i>506 W. 2ND STREET</i>			
3. NAME OF DECEASED:		(First) <i>Harry</i> (Middle) <i>MORTON</i> (Last) <i>Kessler</i>		4. DATE OF DEATH:		(Month) <i>Sept</i> (Day) <i>19</i> (Year) <i>1955</i>	
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>Oct 25, 1909</i>	
9. AGE last birthday: <i>45</i> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <i>Salesman</i>		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>HARRY KESSLER</i>				14. MOTHER'S MAIDEN NAME: <i>STELLA COHEN</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>FREDERICK, MD. MRS. KAY KESSLER - 506 W. 2ND STREET</i>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p><i>150X</i> Immediate cause (a) <i>Carcinoma of esophagus</i> DUE TO</p> <p>Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>DUE TO</i></p> <p>(c)</p>				<i>6 Months</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <i>May 25, 1955</i>		19b. MAJOR FINDINGS OF OPERATION: <i>Carcinoma of esophagus</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 18, 1955</i> , to <i>Sept 19, 1955</i> , that I last saw the deceased alive on <i>Sept 19, 1955</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.					
SIGNATURE <i>S. R. Scholman M.D.</i>		ADDRESS <i>228 N. Market St. Frederick</i>		DATE SIGNED <i>9-19-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		DATE THEREOF <i>SEPT. 21/55</i>		NAME OF CEMETERY OR CREMATORY <i>B'NAI ISRAEL</i>	
LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>		DATE REC'D BY LOCAL REGISTRAR <i>9-20-55</i>		REGISTRAR'S SIGNATURE <i>H.W. Federal</i>	
24. FUNERAL DIRECTOR <i>Holzerman & Bros. Inc. 1124-26 W. North</i>		ADDRESS <i>2000</i>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08694

8710

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick OR TOWN Frederick LENGTH OF STAY (In this place) 5 1/2 years		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital		STREET ADDRESS (If rural, give location) Camp Detrick - nr. Frederick	
3. NAME OF DECEASED (First) CAROLINE (Middle) SOMMER (Last) KRICHAUM	4. DATE (Month) (Day) (Year) OF DEATH September 28 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 12, 1865
9. AGE last birthday 90 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Sommer		14. MOTHER'S MAIDEN NAME Regina Sickenberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT Dr. Carroll E. Krichbaum - Camp Detrick		18. MEDICAL CERTIFICATION Frederick, Md.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a) fracture left leg		INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) (b) 902.0			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) fracture left leg			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inter abdominal excision, primary unknown		19. DATE OF OPERATION Sept 27 1955	
19a. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) Home PLACE (Home, farm, factory, street, OF office bldg., etc.) Home (CITY OR TOWN) Frederick (COUNTY) Frederick (STATE) Md			
TIME (Month) (Day) (Year) (Hour) Sept 27 1955 2 am INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Fell out of bed	
22. I hereby certify that I attended the deceased from 9/27 , 19 55 , to 9/28 , 19 55 , that I last saw the deceased alive on 9/28 , 19 55 , and that death occurred at 8:40 a.m. , from the causes and on the date stated above.			
SIGNATURE Robert A. Pilgram, M.D. (Degree or title)		ADDRESS Frederick, Md. DATE SIGNED 9/28/55	
23. BURIAL, CREMATION, REMOVAL (Specify) Crementation DATE Sept. 30, 1955 NAME OF CEMETERY OR CREMATORY J. William Lee's Sons Co. LOCATION (City, town, or county) Washington, D. C. (State)			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 30 Sept. 1955 Elizabeth G. Heck		24. FUNERAL DIRECTOR C. E. Cline & Son - Frederick, Maryland ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

08695

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

8679

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural, give location) 62 Taney Apts.	
3. NAME OF DECEASED (Type or Print) GEORGE RAY LONG		4. DATE OF DEATH (Month) September (Day) 15 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 16, 1925
9. AGE last birthday 29 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Long, Sr.		14. MOTHER'S MAIDEN NAME Violet Ray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY No. 219-07-2128	
17. INFORMANT AND ADDRESS Mrs. Deloris F. Long, 62 Taney Apts., Frederick, Maryland			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
976X Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (a) Bullet wound right side of skull and back of ear - (b) (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Home	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? Gunshot Wound at Right Temple	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE B. Thomas		DATE SIGNED 9/16/1955	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
DATE REC'D BY LOCAL REG. 17 Sept. 1955		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 20 1955

RECEIVED

8711

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		X	
X TOWN <i>Burkittsville</i>		<i>Life</i>		TOWN <i>Burkittsville</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <i>Blanche</i>		(Middle) <i>M.</i>		(Last) <i>Mahoney</i>		9 24 19 55	
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>6-24-1870</i>	
9. AGE last birthday: <i>85</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <i>John D. Ahalt</i>			
14. MOTHER'S MAIDEN NAME: <i>Hannett Jeannette Willard</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i>			
16. SOCIAL SECURITY No.: <i>—</i>				17. INFORMANT & ADDRESS: <i>Mrs C. W. Miller, Knoxville Md.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
794X Immediate cause (a) <i>Semility</i>						5 yrs.	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>8</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-23-1955</i> , to <i>9-24-1955</i> , that I last saw the deceased alive on <i>9-23-1955</i> , and that death occurred at <i>4:30 p.m.</i> from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		(Degree or title) <i>MD</i>		ADDRESS <i>Brunswick, Md.</i>		DATE SIGNED <i>9-26-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9-27-55</i>		<i>Union</i>		<i>Burkittsville Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>30 Sept. 1955</i>		<i>Elizabeth B. Heck</i>		<i>C. H. Futer & Son</i>		<i>Brunswick Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 3 1955

RECEIVED

8680

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>HOWARD</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
11 TOWN <i>Frederick</i>		7 days		OR TOWN <i>Rural - Woodbine</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Mem</i>				STREET ADDRESS (If rural give location) <i>Daisy 13X-2</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>IRENE E. MARTIN</i>				<i>Sept 20, 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>White</i>	<i>Single</i>	<i>11-11-1873</i>	<i>81</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<i>housework</i>		<i>home</i>		<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Lenox Martin</i>				<i>Rachel Brandenburg</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<i>NO</i>		<i>NONE</i>		<i>Hospital Records</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
463X IMMEDIATE CAUSE						<i>?</i>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
904.0							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Fracture Neck of Femur - left</i>						<i>8 days</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<i>Sept 19, 55</i>		<i>Fracture Neck of Femur</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
		<i>HOME</i>		<i>Woodbine</i>		<i>13 MD</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
<i>Sept 13 1955 P.M.</i>				<i>Fell at home</i>			
22. I hereby certify that I attended the deceased from <i>Sept 13, 1955</i> , to <i>Sept 20, 1955</i> , that I last saw the deceased alive on <i>Sept 20, 1955</i> , and that death occurred at <i>6:10 AM</i> , from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED					
<i>John M. Celler</i>		<i>Sept 20 1955</i>		<i>M. D. 15E Second St. MD</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>9-22-1955</i>		<i>Mt. Carmel</i>		<i>Montg. Co. MD.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>22 Sept 1955</i>		<i>Frank R. Smith, Jr.</i>		<i>C. M. Waltz, Winfield.</i>		<i>MD.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

SEP 28 1955

RECEIVED

8712

CERTIFICATE OF DEATH

Reg. Dist. No. 139.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Cullen, Maryland.		10 days		TOWN Hagerstown		21-03-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hosp.				STREET ADDRESS (If rural give location) 417 Brewer Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Isaac Holland Martin				9 9 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> Widower		8. DATE OF BIRTH: 11/15/1890	
9. AGE last birthday 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical				10B. KIND OF BUSINESS OR INDUSTRY: Electric lineman		11. BIRTHPLACE (State or foreign country): West Virginia	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: Daniel Martin				14. MOTHER'S MAIDEN NAME: Agnes Fuller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Isaac H. Martin 417 Brewer Ave., Hagerstown, Maryland.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary tuberculosis						3 months	
DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/30/1955 , to 9/9/55 19 55 , that I last saw the deceased alive on 9/9/1955 , and that death occurred at 4:15 P.M., from the causes and on the date stated above.							
SIGNATURE J. B. Lyman				ADDRESS M.D. Cullen, Maryland.		DATE SIGNED 9/9/55	
23. BURIAL, CREMATION, REMOVAL, SPECIFY		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/12/1955		Rest Haven Cemetery		Hagerstown, Maryland.	
DATE REC'D BY LOCAL REGISTRAR 9/9/55		REGISTRAR'S SIGNATURE J. B. Lyman		24. FUNERAL DIRECTOR		ADDRESS	
				Rest Haven Funeral Chapel, Inc.		1601 Penn. Ave., Hagerstown, Md.	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 19 1955

RECEIVED

8681

CERTIFICATE OF DEATH

Reg. Dist. No. 131....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) 11 TOWN Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick - Rural X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) Montevue 1			
3. NAME OF DECEASED: (First) (Middle) (Last) VALENTINE E. McCLEERY				4. DATE (Month) (Day) (Year) OF DEATH: September 26, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: Sept. 14, 1868	
9. AGE last birthday 87 yrs.		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday 87 yrs.	
11. BIRTHPLACE (State or foreign country): Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Perry B. McCleery				14. MOTHER'S MAIDEN NAME: Jane E. Doub			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS: Mr. Edward D. Storm, 114-A West Church Street, Frederick, Maryland							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 422.2 Chronic myocarditis						8 yrs.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 25, 1955 , to Sept. 25, 1955 , that I last saw the deceased alive on Sept. 25, 1955 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
SIGNATURE H. J. Keene		M. D. Frederick, Maryland		DATE SIGNED 9/28/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 29, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept. 29, 1955		REGISTRAR'S SIGNATURE Elizabeth B. Herb.		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 3 1955

RECEIVED

8713

CERTIFICATE OF DEATH

Reg. Dist. No. 139.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Cullen		LENGTH OF STAY (in this place) 126 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 04 Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 121 East Third Street					
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
		Ethel		Knott		Mercier	
4. DATE (Month) (Day) (Year) OF DEATH:		Sept. 9,		19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 Hrs. Days	Hours Min.
Female	White	Widow	Aug. 31, 1885	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Housewife		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
David V. Knott				Frances Weaver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		218-34-3643		Patient at above address.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 175X Carcinoma of ovary						4 months.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(1002X) (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						6 months.	
Pulmonary Tuberculosis							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 6, 1955 , to Sept. 9, 1955 that I last saw the deceased alive on Sept. 9, 1955 , and that death occurred at 7:00 M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
Edward P. Ritchie				Cullen, Maryland		September 9, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-12-55		Mt. Olivet Cem.		Frederick, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
9/9/55		[Signature]					

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 13 1955
BUREAU V. S.

8682

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Frederick-Rural RD#5	LENGTH OF STAY (in this place) Since 11/26/49	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 08 Montevue		STREET ADDRESS (If rural give location) 106 East Street	
3. NAME OF DECEASED: (First) (Middle) (Last) WILLIAM HENRY MILLBERRY		4. DATE (Month) (Day) (Year) OF DEATH: September 22, 1955	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 24 May 1870
9. AGE last birthday 85 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Coal Company	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Wesley Millberry	
14. MOTHER'S MAIDEN NAME: Rachel Gaylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) No	
16. SOCIAL SECURITY No. 220-09-7045A		17. INFORMANT & ADDRESS: 210 12th St., Mrs. Alice Killgo, McKeesport 4, Pa.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 422.1			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Chronic myocutaneous			3 yrs.
(B) Arterio sclerosis			3 yrs.
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 6, 1955 to Sept 6, 1955 , that I last saw the deceased alive on Sept 6, 1955 , and that death occurred at 8:05A M, from the causes and on the date stated above.			
SIGNATURE A. McKinn		ADDRESS Frederick, Maryland	
DATE SIGNED 23 Sept 1955		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 26 Sept 1955	NAME OF CEMETERY OR CREMATORY Fairview Cemetery	LOCATION (City, town, or county) (State) Frederick, Maryland
DATE REC'D BY LOCAL REGISTRAR 24 Sept	REGISTRAR'S SIGNATURE Frank R. Smith, Jr.	24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	

DEPUTY LOCAL REGISTRAR

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 26 1955

BUREAU V. S.

8683

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	LENGTH OF STAY (in this place) Months	CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 411 Lee Place		STREET ADDRESS (If rural give location) 27 East Fifth Street	
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES RUSSELL MILLER		4. DATE (Month) (Day) (Year) OF DEATH: September 27, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE MARRIED WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: November 16, 1880
		9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10B. KIND OF BUSINESS OR INDUSTRY: Brick Works	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Charles W. Miller		14. MOTHER'S MAIDEN NAME: Charlotte Sheffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-10-2831	17. INFORMANT & ADDRESS: 27 E. 5th St., Mrs. Mollie D. Miller, Frederick, Maryland
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Heart Failure			3 months
ANTECEDENT CAUSE (S) (B) Arteriosclerotic Heart Disease			2 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertensive Cardiovascular Disease			2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Embolism			1 month
19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE OLD (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 1, 1954 , to 27 Sept, 1955 , that I last saw the deceased alive on 27 Sept, 1955 , and that death occurred at 7:50A M. from the causes and on the date stated above.			
SIGNATURE Thomas E. Stone		M. O. Frederick, Maryland DATE SIGNED 9/28/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Sept. 30, 1955	NAME OF CEMETERY OR CREMATORY Frederick Memorial Park	LOCATION (City, town, or county) (State) Frederick, Maryland
DATE REC'D BY LOCAL REGISTRAR 29 Sept. 1955	REGISTRAR'S SIGNATURE Elizabeth B. Hech	24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1955

BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

08703

Reg. Dist. No. 131

8634

1. PLACE OF DEATH- COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Park Place</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle) <u>Nelson</u>	(Last)
4. DATE OF DEATH	(Month) <u>Sept.</u>	(Day) <u>23</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 23, 1905</u>
9. AGE last birthday <u>50</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
880.0 Immediate cause (a) <u>Poisoning rubbing alcohol</u>	<u>5 hrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
------------------------	----------------------------------	--

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐, suicide ☐, homicide ☐, undetermined ☒.

SIGNATURE _____ (Degree or title) ADDRESS Frederick, Md DATE SIGNED Sept. 26-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Interment</u>	<u>9/27/55</u>	<u>University of Md.</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>27 Sept. 1955</u>	<u>Elizabeth S. Heik</u>	<u>Abraham E. Hicks III</u>	<u>Fred. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1955

BUREAU V. A.

8685

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY *Frederick*

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN *Frederick, Maryland* LENGTH OF STAY (in this place) *2 weeks*

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Frederick Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Maryland*COUNTY *Carroll*

(If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Mt. Airy, Maryland *06X-2*

STREET ADDRESS

Main St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

*Norma**E**Nicodemus*

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month)

(Day)

(Year)

*September 6 1955*10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): *Housewife*10b. KIND OF BUSINESS OR INDUSTRY: *Own Home*11. BIRTHPLACE (State or foreign country): *Maryland*12. CITIZEN OF WHAT COUNTRY? *U. S. A.*

13. FATHER'S NAME:

Francis Engle

14. MOTHER'S MAIDEN NAME:

Ida M. Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Mr. M. L. Nicodemus, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

172X
Immediate cause

(a)

Carcinoma of Uterus

DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Retraction to Bladder and Rectum

DUE TO

(c)

Interval Between Onset And Death

5 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

*Jan. 1951**Carcinoma of Body of Uterus*

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/25*, 1955, to *9/6*, 1955, that I last saw the deceasedalive on *9/6*, 1955, and that death occurred at *4:25 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*8 Sept. 1955**Elizabeth G. Heck**Oliver L. Molesworth, Damascus, Md.*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 13 1955
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 131

8714

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY outside corporate limits, write RURAL and give nearest town)			
OR TOWN Adamstown				OR TOWN Adamstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) LEWIS		(Middle) EDWARD		(Last) OGLE		September 10, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widower	October 31, 1886	68 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Retired Station Agent-B.&O.R.R.						Maryland	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John H. Ogle				Rebecca Medairy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
Yes				Mrs. Mary Scarff, Adamstown, Maryland			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) Coronary occlusion			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(B) Hypertensive - arteriosclerotic heart disease			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March, 1957 , to 9/10, 1955 , that I last saw the deceased alive on 6/18, 1955 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
SIGNATURE James B. Thomas				ADDRESS Frederick, Maryland		DATE SIGNED 9/12/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 13, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 13, 1955		Elizabeth B. Hecker		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 16 1955

RECEIVED

8715

CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Nr. Frederick	LENGTH OF STAY (in this place) 2 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Nr. Frederick	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D. # 4		STREET ADDRESS (If rural give location) R. F. D. # 4	
3. NAME OF DECEASED: (First) (Middle) (Last) BESSIE SHAW ROBERTS		4. DATE OF DEATH: (Month) (Day) (Year) September 19 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: October 3, 1886
9. AGE last birthday: 68 yrs.		10. MONTHS Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own home	
11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Orson Shaw		14. MOTHER'S MAIDEN NAME: Mary Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Mr. Morris W. Roberts - Rt. 4 - Frederick, Md.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X Immediate cause (a) Cerebral hemorrhage		21 days
Antecedent causes (s) (b) Broncho-pneumonia		7 days
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from July 15, 1953, to Sept. 19, 1955, that I last saw the deceased alive on Sept. 18, 1955, and that death occurred at 2:30 P.M., from the causes and on the date stated above.		
SIGNATURE (Degree or title) Bernard O. Thomas, Jr. M.D.		DATE SIGNED Sept. 20, 1955
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	Sept. 21, 1955	Mount Olivet Cemetery
LOCATION (City, town, or county) (State)	Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
20 Sept 1955	Frank R. Smith, Jr.	C. E. Cline & Son - Frederick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 28 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

8686

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	LENGTH OF STAY (in this place) Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural give location) 800 Rosemont Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) NETTIE HENRIETTA ROUGHAN		4. DATE (Month) (Day) (Year) OF DEATH: September 19, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: July 30, 1894
9. AGE last birthday: 61 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) Asst. Treas. & Director		10B. KIND OF BUSINESS OR INDUSTRY: Electric Corp.	
11. BIRTHPLACE (State or foreign country): Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Edward Dubry		14. MOTHER'S MAIDEN NAME: Eliza Coutcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 215-26-2112	
17. INFORMANT & ADDRESS: 800 Rosemont Avenue, Lawrence V. Roughan, Frederick, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Intracranial Hemorrhage			4 days
DUE TO ANTECEDENT CAUSE (B) Gen. arterio-sclerosis and Hypertension			10 years
DUE TO (C) Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 9/19		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1948 , to 9/19 , 19 55 , that I last saw the deceased alive on 18 Sept , 19 55 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above.			
SIGNATURE Charles R. Conley Jr.		DATE SIGNED 9/19/1955	
M. D. Frederick, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 22, 1955	
NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 20 Sept 1955		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland	
REGISTRAR'S SIGNATURE Frank R. Smith, Jr.			
DEPUTY LOCAL REGISTRAR			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 21 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 141

8697

1. PLACE OF DEATH:

COUNTY *Frederick* MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) *35 Brunnsuick* LENGTH OF STAY (in this place) *2 wks*
HOSPITAL OR INSTITUTION OR STREET ADDRESS *5 West B*

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Pa* COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN *Sharon* 75X-3
STREET ADDRESS (If rural, give location) *386 A Street*

3. NAME OF DECEASED: (Type or Print)

(First) *Metta* (Middle) *E.* (Last) *Sewell*

4. DATE OF DEATH: (Month) *9* (Day) *18* (Year) *19 55*

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED,

Married

8. DATE OF BIRTH:

2-14-1876

9. AGE last birthday: *79* yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Germany

12. CITIZEN OF WHAT COUNTRY?

Germany

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Mr M. Sewell Sharon Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

421.4

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

8

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9/13/55* to *9/14/55*, that I last saw the deceased alive on *9/13/55*, and that death occurred at *13:00* m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED *9/16/55*

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

9-7-55

NAME OF CEMETERY OR CREMATORY

Loudon Park

LOCATION (City, town, or county)

Baltimore Maryland

(STATE)

DATE REC'D BY LOCAL REG.

Sept 4-55

REGISTRAR'S SIGNATURE

Kathryn H. Brown

24. FUNERAL DIRECTOR

C. H. Leeler 34 Brunswick Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 13 1955

RECEIVED

8716

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural-Myersville</u>		<u>10 min.</u>		TOWN <u>Myersville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Myersville, Rt. #1</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED:			4. DATE OF DEATH:				
(First) (Middle) (Last)			(Month) (Day) (Year)				
<u>WILLIAM STARTZMAN SHEPLEY</u>			<u>September 17 1955</u>				
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>June 19, 1871</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Gen. Farming</u>		<u>Frederick Co. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Frederick Shepley</u>				<u>Cynthia Pryor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>Mrs. E.R. Eccard, Myersville, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u>						<u>25 Min.</u>	
Antecedent causes (s) (b) <u>Arterio Sclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 17, 1955</u> to <u>Sept 17, 1955</u> , that I last saw the deceased alive on <u>Sept 17, 1955</u> , and that death occurred at <u>11:10 A</u> from the causes and on the date stated above.							
SIGNATURE <u>J. E. Hoop Md</u>				DATE SIGNED <u>Sept 17 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 20, 1955</u>		<u>St. Paul's Luth.</u>		<u>Myersville, Fred. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 20, 1955</u>		<u>J. M. Bittle</u>		<u>Paul F. Bittle, Myersville, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 22 1965

RECEIVED

8898

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY

Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

35 Brunswick

LENGTH OF STAY (in this place)

10 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00 110 "A" Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Frederick

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Brunswick

STREET ADDRESS (If rural, give location)

110 "A" Street

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

William Franklin Sheppard

4. DATE OF DEATH:

(Month)

(Day)

(Year)

9

5

1955

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

7-7-1869

9. AGE last birthday:

86 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

West Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

William Sheppard

14. MOTHER'S MAIDEN NAME:

Mary Susan Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

58-14-7378A

17. INFORMANT & ADDRESS:

Mr W.F. Sheppard, Brunswick Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c).....

Coronary occlusion
Sclerotic

INTERVAL BETWEEN ONSET AND DEATH

Rapid
yes

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1948, to....., 9-5-1955, that I last saw the deceased alive on....., 9-5-1955, and that death occurred at....., 5:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DECREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

Burial

DATE THEREOF

9-7-55

NAME OF CEMETERY OR CREMATORY

Greenwood

LOCATION (City, town, or county)

Marriott Virginia

(State)

Md

DATE REC'D BY LOCAL REG

Sept 6-55

REGISTRAR'S SIGNATURE

Kathryn N. Brown

24. FUNERAL DIRECTOR

C.H. Fisher

ADDRESS

Brunswick Md

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8717

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08711

Reg. Dist.

No. 145-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write OR and give nearest town) <i>Rural</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <i>Frederick</i>		11	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Highway - Route 40 West</i>				STREET ADDRESS (If rural, give location) <i>125 W. Church St.</i>		1	
3. NAME OF DECEASED: (First) <i>Charles</i> (Middle) <i>E</i> (Last) <i>Shilling</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Sept. 23 1955</i>			
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>SINGLE</i>	8. DATE OF BIRTH: <i>2-26-1921</i>	9. AGE last birthday: <i>34</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Day WORK</i>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Harvey A. Shilling</i>				14. MOTHER'S MAIDEN NAME: <i>Bessie May Fogle</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i> (If Yes, give war or dates of service) <i>W WAR II</i>		16. SOCIAL SECURITY No.: <i>214-10-4457</i>		17. INFORMANT & ADDRESS: <i>Mrs. Bessie M. Shilling - Hagerstown - Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
816x Immediate cause		(a) <i>Broken neck, crushed bones rt side of face, crushed left side of chest from front to eighth rib</i>				<i>Instantaneous</i>	
Antecedent cause(s)		(b) <i>Side of chest from front to eighth rib</i>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Highway</i>		21c. (City or town) (County) (State) <i>Route 40, Frederick Md</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Sept. 23-55 9:15 AM</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Auto ran into back truck & trailer</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>B. B. Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>9-26-55</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		LOCATION (City, town, or county) (State) <i>Frederick - Md.</i>	
DATE REC'D BY LOCAL REG. <i>25 Sept. 1955</i>		REGISTRAR'S SIGNATURE <i>Floyd M. Bittle</i>		24. FUNERAL DIRECTOR <i>C. E. Cline & Son</i>		ADDRESS <i>Frederick - Md.</i>	

BUREAU V. E.

SEP 28 1955

RECEIVED

8697

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)		RURAL and give nearest town)	
11 <u>Frederick</u>		<u>Years</u>		11 <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>321 South Market Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		CORA DELIAH SHULL		4. DATE (Month) (Day) (Year)		OF DEATH: <u>September 1, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 9, 1880</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Penna.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles M. Little</u>				<u>Emma J. Heilman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>321 South Market St. Rev. Dr. Charles H. Shull, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						<u>1 mo</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
<u>260X</u> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>1 mo.</u>	
<u>Diabetes Mellitus</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 31, 1955</u> , to <u>Sept 1, 1955</u> , that I last saw the deceased alive on <u>Sept 1, 1955</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>A. A. Scarre</u>		<u>Frederick, Maryland</u>		<u>9/1/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 3, 1955</u>		<u>Frederick Memorial Park</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2 Sept. 1955</u>		<u>Elizabeth G. Hech</u>		<u>M. R. Etchison & Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 7 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08713

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural give location) <u>115 Record Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES ASBURY SIFFORD</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>September 3, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 16, 1878</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John E. Sifford</u>		14. MOTHER'S MAIDEN NAME: <u>Susan A. B. Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-1900</u>	
17. INFORMANT & ADDRESS: <u>115 Record Street, Mrs. Elizabeth T. Sifford, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>			<u>1 year</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic Nephritis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1954</u> , to <u>Sept. 3, 1955</u> , that I last saw the deceased alive on <u>Sept. 3, 1955</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. A. Pearce</u>		M. D. <u>Frederick, Maryland</u> DATE SIGNED <u>9/6/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>Sept. 7, 1955</u>	<u>Mount Olivet Cemetery Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>6 Sept. 1955</u>	<u>Elizabeth L. Heck</u>	<u>M. R. Etchison & Son, Frederick, Maryland</u>	

BUREAU V. S.

SEP 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08714

8718

CERTIFICATE OF DEATH

Reg. Dist. No. 131 WC

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick County Chronic Hospital</u>		STREET ADDRESS (If rural, give location) <u>6. 4th St. 6 x t.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Dorothy</u>			<u>Strauder</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>MAY 26 - 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>Domestic</u>			<u>49</u> yrs.
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
<u>Thomas Strauder</u>		<u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY	
<u>No</u>		<u>USA</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
		<u>Martha Murdock</u>	
17. INFORMANT			
<u>John T. Strauder</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>422.2</u>		(a) <u>Chronic myocarditis</u>		<u>3 yrs.</u>	
Antecedent cause(s)		(b) <u>Pulmonary Embolism</u>		<u>5 days</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
<u>8</u>				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
OF INJURY		m.			

22. I hereby certify that I attended the deceased from....., 1952, to Sept 22, 1955, that I last saw the deceased alive on 9-20, 1955, and that death occurred at 6:25 p.m., from the causes and on the date stated above.

SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>H. Kline M.D.</u>				<u>Frederick Md</u>		<u>Sept 22</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Sept 22 - 55</u>		<u>FAIRVIEW</u>		<u>Frederick - Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 22, 1955</u>		<u>Frank R. Smith, Jr.</u>		<u>Charles E. Hicks</u>		<u>271 Fred Md.</u>	

DEPUTY LOCAL REGISTRAR

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 26 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08715

8689

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>52 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>147 West South Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CLARENCE</u> <u>LaMOTTE</u> <u>STRINE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 29, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>		8. DATE OF BIRTH: <u>June 24, 1877</u>	
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Messenger</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Messenger</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Post Office Dept.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Francis T. Strine</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Mentzer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>147 West South Street</u> <u>Mrs. Harry B. Grove, Frederick, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>3 weeks</u>	
ANTECEDENT CAUSE (S) <u>Acute Pyelonephritis</u>						<u>4 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Arteriosclerotic Heart Disease</u>						<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>24 Sept, 1955</u> , that I last saw the deceased alive on <u>24 Sept</u> , 19 <u>55</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas C. Strine</u>		M. D. <u>Frederick, Maryland</u>		DATE SIGNED <u>10/1/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodsboro, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1 October 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hesk</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison & Son, Frederick, Maryland</u>			

BUREAU V. S.

OCT 4 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08716

8690

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick			
11 TOWN Frederick		Years		STREET ADDRESS (If rural give location) 10 West Fifth Street			
69 HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
DECEASED: (Type or Print) MARY EDNA SWEENEY		DATE: September 23, 1955					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Married	8 Oct 1887	67 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		10B. KIND OF BUSINESS OR INDUSTRY: At Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Speaks				14. MOTHER'S MAIEN NAME: Mary Elizabeth Sweeney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: 10 W. 5th St., Stanley C. Sweeney, Frederick, Maryland			
15 No							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONOITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of Stomach							1 year
ANTECEDENT CAUSE (S) DUE TO Arteriosclerotic Heart Disease							3 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X DUE TO Diabetes Mellitus							10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1953 , to 23 Sept, 1955 , that I last saw the deceased alive on 23 Sept, 1955 , and that death occurred at 6 PM , from the causes and on the date stated above.							
SIGNATURE Thomas E. Stone		M. D. 4 W 3rd St		ADDRESS 9-23-55		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 26 Sept 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 24 Sept 1955		REGISTRAR'S SIGNATURE Frank R. Smith, Jr.		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

BUREAU V. 2

SEP 28 1955

RECEIVED

8699

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

COUNTY

Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

35 Brunswick

LENGTH OF STAY (in this place)

35 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

3 Second Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Frederick

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN Brunswick

35

STREET ADDRESS (If rural, give location)

3 Second Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

George Franklin Taylor

4. DATE OF DEATH:

(Month)

(Day)

(Year)

9-16

1955

5. SEX:

male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

7-16-1900

9. AGE last birthday:

55 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

B+C O R R C

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME:

David F. Taylor

14. MOTHER'S MAIDEN NAME:

Bertha Linda Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

705-10-2726

17. INFORMANT & ADDRESS:

Mr. Ed Taylor Brunswick Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

593X

Immediate cause

(a) DUE TO

Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Bright's Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 days

5 yrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15-55 to 9-16-55, that I last saw the deceased alive on 9-16-55, and that death occurred at 8:00 p.m. from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

9-17-55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

9-19-55

NAME OF CEMETERY OR CREMATORY

Samples Manor

LOCATION (City, town, or county)

Samples Manor Md

(State)

DATE REC'D BY LOCAL REG.

Sept 17-55

REGISTRAR'S SIGNATURE

Ralph N. Brown

24. FUNERAL DIRECTOR

C. A. Gills + Son

ADDRESS

Brunswick Md

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1955

BUREAU V. B.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8692

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08718

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Fred.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Middletown</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred. Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Earl T. Tritapoe</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>9 13 1955</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	8. DATE OF BIRTH: <i>10-24-1885</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>unemployed</i>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>
13. FATHER'S NAME: <i>Samuel Tritapoe</i>				14. MOTHER'S MAIDEN NAME: <i>Lizzie Daniel</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Mrs. Vera Poffenberger, Middletown, Md.</i>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.0</i>							
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>arteriosclerosis, generalized</i>						Years.	
(B) <i>arteriosclerotic heart disease</i>						10 years.	
(C) <i>dissecting aneurysm</i>						24 hours.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-12</i> , 1955, to <i>9-13</i> , 1955, that I last saw the deceased alive on <i>9-13</i> , 1955, and that death occurred at <i>11:00 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert S. Jernigan</i>		M. D. <i>J E. Church St. Frederick</i>		DATE SIGNED <i>9-16-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-15-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Jefferson Cemetery</i>		LOCATION (City, town, or county) (State) <i>Jefferson Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>14 Sept. 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>		24. FUNERAL DIRECTOR <i>Bladhill Co.</i>		ADDRESS <i>Middletown, Md.</i>	

BUREAU V. S.

SEP 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808719

8691

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) // Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) // Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 115 West Fourth Street			
3. NAME OF DECEASED: (First) (Middle) (Last) CLAYBORNE TROXELL				4. DATE (Month) (Day) (Year) OF DEATH: September 12, 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: August 7, 1880	9. AGE last birthday: 75 yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life): Retired Motorman		10B. KIND OF BUSINESS OR INDUSTRY: H. & F. Railway		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles P. Troxell				14. MOTHER'S MAIDEN NAME: Elizabeth Lohr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: 7 Frederick Avenue, Mr. Charles E. Troxell, Frederick, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) Myocardial Infarction						4 days	
ANTECEDENT CAUSE (S) (B) Old Myocardial Infarction						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerotic Heart Disease						5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1953, to Sept. 12, 1955, that I last saw the deceased alive on Sept. 12, 1955, and that death occurred at 5:05 PM, from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
Thomas C. Stone		Frederick, Maryland		9/14/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 15, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
14 Sept. 1955		Elizabeth B. Heck-		M. R. Etchison & Son, Frederick, Maryland			

BUREAU V. S.

SEP 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

08720

Reg. Dist. No. 131

8719

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Near Urbana</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ijamsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>England Farm-Big Woods Road</u>		STREET ADDRESS (If rural, give location) <u>/</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOY</u>	(Middle) <u>ANNATTE</u>	(Last) <u>TYERYAR</u>
4. DATE OF DEATH	(Month) <u>September</u>	(Day) <u>3,</u>	(Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 12, 1953</u>
9. AGE last birthday <u>2</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles S. Tyeryar</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis England</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Charles S. Tyeryar, Ijamsville, Maryland</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>929.0</u> Immediate cause (a) <u> </u> Antecedent cause(s) (b) <u> </u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min. or less</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Near Urbana Frederick Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Fell in pond about 11:45 A.M.</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>B. Thomas</u>		ADDRESS <u>Dep. Med. Exam, Frederick, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 6, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 1955</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>	
REGISTRAR'S SIGNATURE <u>Elizabeth S. Hecker</u>		ADDRESS <u>M. R. Etchison & Son, Frederick, Maryland</u>	

RECEIVED

SEP 7 1955

BUREAU V. A.

4811

8720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md.		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X Sabillasville		25 Yrs.		Sabillasville X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60							
3. NAME OF DECEASED: (First) Jane		(Middle) E.		(Last) Waynant		4. DATE (Month) (Day) (Year) OF DEATH: Sept. 11, 1955	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: Jan. 15, 1871	
9. AGE last birthday: 84 yrs.		10. AGE last birthday: 84 yrs.		11. BIRTHPLACE (State or foreign country): Waynesboro		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired				10B. KIND OF BUSINESS OR INDUSTRY: Store Clerk			
13. FATHER'S NAME: A. E. Waynant				14. MOTHER'S MAIDEN NAME: Marion Bender			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mrs. H. P. Harbaugh, Waynesboro Pa.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 422.1 Semility						1 yr.	
ANTECEDENT CAUSE (B) Arteriosclerosis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic myocarditis						?	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 7, 1946 , to Sept. 11, 1955 , that I last saw the deceased alive on Sept. 10, 1955 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.							
SIGNATURE M. Franklin Birch				M. D. Thurmond T. D.		DATE SIGNED 9/14/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/14/55		NAME OF CEMETERY OR CREMATORY Green Hill		LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.	
DATE REC'D BY LOCAL REGISTRAR 9/19/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Walter Y. Groves		ADDRESS Waynesboro Pa.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08722

8721

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - near Thurmont</u> TOWN <u>Rural - near Thurmont</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. #1</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - near Thurmont</u> TOWN <u>Rural - near Thurmont</u> STREET ADDRESS <u>Rt. #1</u>	
3. NAME OF DECEASED (Type or Print) <u>MONROE ELSWORTH WETZEL JR.</u>		4. DATE OF DEATH (Month) <u>Sept.</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 25, 1955</u>
9. AGE last birthday <u>0</u> yrs. <u>0</u> months <u>0</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Monroe Elsworth Wetzels jr.</u>		14. MOTHER'S MAIDEN NAME <u>Estella Mae Moser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Monroe E. Wetzels, Sr. Rt. 1 Thurmont, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4 Immediate cause	(a) <u>Congenital heart anomaly</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 hr. 15 min.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) _____	
(c) _____		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 25, 1955, to Sept. 25, 1955, that I last saw the deceased alive on Sept. 25, 1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

SIGNATURE M. Franklin Birch M.D. (Degree or title) ADDRESS Thurmont, Md. DATE SIGNED Sept. 25, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept. 26, 1955</u>	<u>Mountain View</u>	<u>Emmitsburg Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>9/26/55</u>	<u>L. C. Powell</u>	<u>Powell & Hartzler</u>	<u>2 Woodrow</u>

1015223393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 28 1955

RECEIVED

8722

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Braddock Heights		5 months		OR Frederick		//	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 Vindobona Convalescent Home				404 West Second Street			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		NORINE				WHITEHILL	
5. SEX:		5. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Widowed		July 11, 1873	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
82 yrs.		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				Own Home		Maryland	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Harry Douy				Kate Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
4 No				None		(son) Mr. H. Webster Whitehill - Frederick, Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset and Death	
420.0 Immediate cause						20-30 min.	
(a) Acute pulmonary edema							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.						10 yrs +	
(b) Arteriosclerotic Heart Disease							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
				INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work		Not While At Work			
22. I hereby certify that I attended the deceased from Dec 1953, to Sep 9, 1955, that I last saw the deceased alive on Sep 9, 1955, and that death occurred at 4:15 AM, from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Henry V. Chase M.D.		4 E. Church St Frederick Md				9/9/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/11/55		Linganore Cemetery		Unionville, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
10 Sept. 1955		Elizabeth L. Hecla		C. E. Cline & Son - 8 East Patrick Street Frederick, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 13 1935

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08724

8693

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Fred.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		LENGTH OF STAY (in this place) 4 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 319 Madison Street				STREET ADDRESS 319 Madison Street			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:		5. AGE last birthday:	
(First) Williams (Middle) Edward (Last) Nathan				(Month) Sept. (Day) 29 (Year) 19 55		IF UNDER 1 YEAR IF UNDER 24 HRS.	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:		10. MONTHS, DAYS, HOURS, MIN.	
Male	Colored	Single	Jan. 1, 1875	80 yrs.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Railroad				10b. KIND OF BUSINESS OR INDUSTRY: *****		11. BIRTHPLACE (State or foreign country): Montgomery Co., Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: Harplus Williams				14. MOTHER'S MAIDEN NAME: Laura Fisher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Odie Bell 319 Madison Street	
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Ch. Cerebral Vascular Disease				6 months			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-4-1955 , to 9-29-1955 , that I last saw the deceased alive on 9-29-1955 , and that death occurred at 9:30 P , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
U. B. Brown Jr.				Sept 29		9/30/55	
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				Oct. 2, 1955		St. Pauls	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Oct. 19 1955				Elizabeth S. Heck		Charles E. Hicks III, Frederick, Md.	

BUREAU V. S.

OCT 4 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 188725

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Brunswick		37 years		TOWN Brunswick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		114 \$ 4th.Ave.		STREET ADDRESS (If rural, give location)			
				114 4th.Ave			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) William		(Middle) Robert		(Last) Williams		(Month) 9 (Day) 11 (Year) 55	
(Type or Print)							
5. SEX:	6. COLOR OR	7. SINGLE, MARRIED,	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	7-16-1885	65	Months	Days	Hours Min.
		(Specify)	90	yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Brakeman		B and O.R.R.Co.		West Virginia		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Ashby Williams				Elizabeth Crimm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No				Mrs. Betty Koogle Williams, Brunswick, Md			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1							
Immediate cause (a).....							
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS:							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:					20. AUTOPSY?
							Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF		While at					
INJURY		M. work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 9-11-55 , to 9-11-55 , that I last saw the deceased alive on 9-11-55 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE)		DATE SIGNED	
[Signature]				[Signature]		9-11-55	
23. BURIAL CREMATION		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial (Specify):		9-14-55		Lutheran		Middletown, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept 12-55		Kathryn H. Brown		C.H. Feete and Bro.		Brunswick, Md.	

BUREAU V. S.

SEP 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8723

08726

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH: Near Smithsburg (Rural)		2. USUAL RESIDENCE (HOME) OF DECEASED: Near Smithsburg (Rural)	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
<input checked="" type="checkbox"/> TOWN RURAL	Lifetime	RURAL	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) /	
3. NAME OF DECEASED: (First) Alvie (Middle) Sylvester (Last) Wolfe		4. DATE (Month) (Day) (Year) OF DEATH: Sept. 3 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH: Oct. 22 1900
9. AGE last birthday 54 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Frederick Co., MD.	
11. BIRTHPLACE (State or foreign country): U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Jack Wolfe		14. MOTHER'S MAIDEN NAME: Blanche Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-2260	
17. INFORMANT & ADDRESS: Keller Wolfe Woodsboro, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
201X IMMEDIATE CAUSE (A) Hodgskin's disease			6 mo.
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 31, 1955 , to Sept. 3, 1955 , that I last saw the deceased alive on Sept. 2, 1955 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
SIGNATURE M. Frank Bink		DATE SIGNED 9/3/55	
M.D. Thurmont Ind.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Sept. 5 1955	NAME OF CEMETERY OR CREMATORY Mt. Bethel	
LOCATION (City, town, or county) Near Garfield Fredk. Md.		(State)	
DATE REC'D BY LOCAL REGISTRAR Sept. 4 1955	REGISTRAR'S SIGNATURE Blanche S. Eyles	24. FUNERAL DIRECTOR W. C. Cragg	
ADDRESS Thurmont			

LETTER TO THE DIRECTOR

1955

BUREAU V. S.

SEP 9 1955

RECEIVED

8694

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>12 hrs</u>		If outside corporate limits, write RURAL and give nearest town OR TOWN <u>Thurmont</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ESTEE BAINE ZENTZ</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 12 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 2, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Electrician's Inspector - Restingtown</u>				11. BIRTHPLACE (State or foreign country): <u>Frederick Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Daniel W. Zentz</u>				14. MOTHER'S MAIDEN NAME: <u>Effie G. Lohr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>372-16-0203</u>		17. INFORMANT & ADDRESS: <u>Eva Zentz - Thurmont Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Myocardial Infarction</u>						<u>3 1/2 days</u>	
(B) <u>Anterior subacute Myocardial Infarction</u>						<u>1 year</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>11 AM</u> , 1955, to <u>12 AM</u> , 1955, that I last saw the deceased alive on <u>11 AM</u> , 1955, and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Stone</u>		ADDRESS <u>4 W 3rd St</u>		DATE SIGNED <u>9-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>United Brethren</u>		LOCATION (City, town, or county) (State) <u>Thurmont, Fred. Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		24. FUNERAL DIRECTOR <u>M. L. Craggs & Son</u>		ADDRESS <u>Thurmont, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8695

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08728

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick	LENGTH OF STAY (in this place) 50 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 502 East Patrick Street	STREET ADDRESS (If rural give location) 502 East Patrick Street		
3. NAME OF DECEASED: (First) (Middle) (Last) MARY MARGARET JEANETTE ZIMMERMAN		4. DATE (Month) (Day) (Year) OF DEATH: September 28, 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE MARRIED WIDOWED WIDOW (Specify)	8. DATE OF BIRTH: 12 Dec 1858
9. AGE last birthday 96 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		10B. KIND OF BUSINESS OR INDUSTRY: At Home	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Lewis Stull		14. MOTHER'S MAIDEN NAME: Anna Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Mrs. R. V. Stull, RD#3, Frederick, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Chronic myosarcoma			10 yrs.
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 21, 1955 to Sept 21, 1955 , that I last saw the deceased alive on Sept 21, 1955 , and that death occurred at 4 PM , from the causes and on the date stated above.			
SIGNATURE H. H. Kline		M. D. Frederick, Maryland 29 Sept 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1 Oct 1955	Zion Reformed Cemetery	Charlesville, Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
Sept. 30, 1955	Elizabeth G. Heck	M. R. Etchison & Son, Frederick, Maryland	

RECEIVED

OCT 3 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8696

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08729

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) 11 Frederick	LENGTH OF STAY (in this place) Years	CITY (If outside corporate limits, write RURAL and give nearest town) 10 Frederick-Rural-R.D.#3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital		STREET ADDRESS (If rural give location) Bloomfield	
3. NAME OF DECEASED: (First) (Middle) (Last) SUSIE EDITH ZIMMERMAN		4. DATE (Month) (Day) (Year) OF DEATH: Sept. 27, 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow	8. DATE OF BIRTH: November 1, 1886
9. AGE last birthday 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas F. Haugh		14. MOTHER'S MAIDEN NAME: Ida Adelaide Eyler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Raymond A. Haugh Sr., Frederick R.D.#3, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cyrtadenocarcinoma of ovary with metastases			1 yr.
ANTECEDENT CAUSE (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 6-6 , 19 55 , to 9-27 , 19 55 that I last saw the deceased alive on 9-25 , 19 55 , and that death occurred at 9:15AM , from the causes and on the date stated above.			
SIGNATURE Dr. R. Martin		DATE SIGNED 9/28/1955	
ADDRESS _____		M. D. Frederick, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 30, 1955	
NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 29 Sept. 1955		REGISTRAR'S SIGNATURE Elizabeth G. Hach	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS _____	

RECEIVED

SEP 30 1955

BUREAU Y. S.